



## Senate

General Assembly

February Session, 2010

**File No. 236**

Senate Bill No. 67

*Senate, April 1, 2010*

The Committee on Human Services reported through SEN. DOYLE of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

### **AN ACT CONCERNING ANNUAL BENEFITS AVAILABLE UNDER THE CHARTER OAK HEALTH PLAN.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-311 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective July 1, 2010*):

3 (a) There is established the Charter Oak Health Plan for the purpose  
4 of providing access to health insurance coverage for state residents  
5 who have been uninsured for at least six months and who are  
6 ineligible for other publicly funded health insurance plans. The  
7 Commissioner of Social Services may enter into contracts for the  
8 provision of comprehensive health care for such uninsured state  
9 residents. The commissioner shall conduct outreach to facilitate  
10 enrollment in the plan.

11 (b) The commissioner shall impose cost-sharing requirements in  
12 connection with services provided under the Charter Oak Health Plan.  
13 Such requirements may include, but not be limited to: (1) A monthly

14 premium; (2) an annual deductible not to exceed one thousand dollars;  
15 (3) a coinsurance payment not to exceed twenty per cent after the  
16 deductible amount is met; (4) tiered copayments for prescription drugs  
17 determined by whether the drug is generic or brand name, formulary  
18 or nonformulary and whether purchased through mail order; (5) no fee  
19 for emergency visits to hospital emergency rooms; (6) a copayment not  
20 to exceed one hundred fifty dollars for nonemergency visits to hospital  
21 emergency rooms; and (7) a lifetime benefit not to exceed one million  
22 dollars.

23 (c) The Commissioner of Social Services shall provide premium  
24 assistance to eligible state residents whose gross annual income does  
25 not exceed three hundred per cent of the federal poverty level. Such  
26 premium assistance shall be limited to: (1) One hundred seventy-five  
27 dollars per month for individuals whose gross annual income is below  
28 one hundred fifty per cent of the federal poverty level; (2) one hundred  
29 fifty dollars per month for individuals whose gross annual income is at  
30 or above one hundred fifty per cent of the federal poverty level but not  
31 more than one hundred eighty-five per cent of the federal poverty  
32 level; (3) seventy-five dollars per month for individuals whose gross  
33 annual income is above one hundred eighty-five per cent of the federal  
34 poverty level but not more than two hundred thirty-five per cent of the  
35 federal poverty level; and (4) fifty dollars per month for individuals  
36 whose gross annual income is above two hundred thirty-five per cent  
37 of the federal poverty level but not more than three hundred per cent  
38 of the federal poverty level. Individuals insured under the Charter Oak  
39 Health Plan shall pay their share of payment for coverage in the plan  
40 directly to the insurer.

41 (d) The Commissioner of Social Services shall determine minimum  
42 requirements on the amount, duration and scope of benefits under the  
43 Charter Oak Health Plan, except that [there] (1): There shall be no  
44 preexisting condition exclusion; and (2) a plan participant who has not  
45 exceeded the lifetime benefit shall not be denied coverage for medical  
46 treatment that the commissioner determines, based on available  
47 medical evidence, to be medically necessary. Each participating insurer

48 shall provide an internal grievance process by which an insured may  
49 request and be provided a review of a denial of coverage under the  
50 plan.

51 (e) The Commissioner of Social Services may contract with the  
52 following entities for the purposes of this section: (1) A health care  
53 center subject to the provisions of chapter 698a; (2) a consortium of  
54 federally qualified health centers and other community-based  
55 providers of health services which are funded by the state; or (3) other  
56 consortia of providers of health care services established for the  
57 purposes of this section. Providers of comprehensive health care  
58 services as described in subdivisions (2) and (3) of this subsection shall  
59 not be subject to the provisions of chapter 698a. Any such provider  
60 shall be certified by the commissioner to participate in the Charter Oak  
61 Health Plan in accordance with criteria established by the  
62 commissioner, including, but not limited to, minimum reserve fund  
63 requirements.

64 (f) The Commissioner of Social Services shall seek proposals from  
65 entities described in subsection (e) of this section based on the cost  
66 sharing and benefits described in subsections (b) and (c) of this section.  
67 The commissioner may approve an alternative plan in order to make  
68 coverage options available to those eligible to be insured under the  
69 plan.

70 (g) The Commissioner of Social Services, pursuant to section 17b-10,  
71 may implement policies and procedures to administer the provisions  
72 of this section while in the process of adopting such policies and  
73 procedures as regulation, provided the commissioner prints notice of  
74 the intent to adopt the regulation in the Connecticut Law Journal not  
75 later than twenty days after the date of implementation. Such policies  
76 shall be valid until the time final regulations are adopted and may  
77 include: (1) Exceptions to the requirement that a resident be uninsured  
78 for at least six months to be eligible for the Charter Oak Health Plan;  
79 and (2) requirements for open enrollment and limitations on the ability  
80 of enrollees to change plans between such open enrollment periods.

This act shall take effect as follows and shall amend the following sections:
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Section 1	<i>July 1, 2010</i>	17b-311
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**HS**      *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

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### ***OFA Fiscal Note***

#### ***State Impact:***

<b>Agency Affected</b>	<b>Fund-Effect</b>
Department of Social Services	GF - Uncertain

Note: GF=General Fund

***Municipal Impact:*** None

#### ***Explanation***

The bill allows a Charter Oak enrollee to exceed their annual benefit cap (\$100,000) if they have not exceeded their lifetime benefit cap (\$1 million). This change is likely to alter the actuarial based premiums for the program (currently \$296 per month). These premium changes would be either absorbed by the enrollee or the state, depending upon the extent to which any changes are passed on to enrollees through increased cost sharing. Currently, the state spends approximately \$24 million annually in subsidies for approximately 11,500 clients.

#### ***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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**OLR Bill Analysis****SB 67*****AN ACT CONCERNING ANNUAL BENEFITS AVAILABLE UNDER THE CHARTER OAK HEALTH PLAN.*****SUMMARY:**

By law, the Department of Social Services (DSS) commissioner must set minimum amount, duration, and scope of benefits in the Charter Oak Health Plan. Through draft regulations, the commissioner has set an annual benefit cap of \$100,000. This bill prohibits the plan from denying coverage for medical treatment to someone (1) the commissioner determines, based on medical evidence, needs “medically necessary” care and (2) who has not exceeded the program’s \$1 million lifetime benefit limit.

EFFECTIVE DATE: July 1, 2010

**BACKGROUND*****Medical Necessity Definition***

Although not defined in law, DSS uses the following medical necessity definition in the Charter Oak Health Plan, as found in the program’s draft regulations and contracts with MCOs.

“Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or prevent a medical condition or prevent a medical condition from occurring” (*Draft Conn. Agency Regs*, § 17b-311-2).

***Related Bill***

sHB 5296, reported favorably by the Human Services Committee, changes the definition of medical necessity.

**COMMITTEE ACTION**

Human Services Committee

Joint Favorable

Yea    19    Nay   0    (03/18/2010)